SAINT PAUL SCHOOL

Education for Tomorrow, Faith for a Lifetime

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Authorization for Medication to be Given During School Hours

The following section is to be completed by the PARENT:

Child's Name_____ _____ _____
Last First Sex Date of Birth

_____ _____
School Grade

_____ _____
Physician's Name Address Telephone

I request that my child be assisted in taking the medicine(s) described below at school by authorized Persons as ordered by my physician (see below).

The following is to be completed by the PHYSICIAN:
Diagnosis for which medication is to be given:_____

Name of Medicine:
Form:
Dose:
If medication is to be given DAILY, at what time?
If medication is to be given PRN, how often?
How soon may the PRM medication be repeated?
Is this medication required on class trips?
List significant side effects:
Length of time medication is recommended:

Additional information: _____
_____

Date: _____ Physician's Signature:_____